DO NOT STAPLE IN BAR AREA

[redacted]

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS)
MEDICAL ASSISTANCE ADMINISTRATION (MAA)

INTERNAL CONTROL NUMBER (DSHS USE ONLY)

PHARMACY STATEMENT (525-106)

PRINT OR TYPE ALL INFORMATION

PROVIDER NAME AND ADDRESS	NABP NUMBER

PATIENT IDENTIFICATION
(COPY FROM MEDICAL IDENTIFICATION CARD)

FI	MI	BIRTHDATE	LAST NAME	TB

4. PATIENT NAME AND ADDRESS

DETAIL CLAIM INFORMATION

1

PRESCRIPTION NUMBER	REFILL CODE	NURSING HOME	DATE WRITTEN	DATE FILLED	QUANTITY PRESCRIBED	QUANTITY FILLED	TOTAL CHARGE
		☐ Yes ☐ No					

EST. DAYS SUPPLY	NATIONAL DRUG CODE	DRUG NAME	PAYABLE BY PATIENT

PRESCRIBER'S ID	PRESCRIPTION (DIRECTIONS FOR USE)	AUTHORIZATION NUMBER	INSURANCE PAID AMOUNT

GENERIC	JUSTIFICATION/COMMENTS	BALANCE DUE
☐ Yes ☐ No		

2

PRESCRIPTION NUMBER	REFILL CODE	NURSING HOME	DATE WRITTEN	DATE FILLED	QUANTITY PRESCRIBED	QUANTITY FILLED	TOTAL CHARGE
		☐ Yes ☐ No					

EST. DAYS SUPPLY	NATIONAL DRUG CODE	DRUG NAME	PAYABLE BY PATIENT

PRESCRIBER'S ID	PRESCRIPTION (DIRECTIONS FOR USE)	AUTHORIZATION NUMBER	INSURANCE PAID AMOUNT

GENERIC	JUSTIFICATION/COMMENTS	BALANCE DUE
☐ Yes ☐ No		

3

PRESCRIPTION NUMBER	REFILL CODE	NURSING HOME	DATE WRITTEN	DATE FILLED	QUANTITY PRESCRIBED	QUANTITY FILLED	TOTAL CHARGE
		☐ Yes ☐ No					

EST. DAYS SUPPLY	NATIONAL DRUG CODE	DRUG NAME	PAYABLE BY PATIENT

PRESCRIBER'S ID	PRESCRIPTION (DIRECTIONS FOR USE)	AUTHORIZATION NUMBER	INSURANCE PAID AMOUNT

GENERIC	JUSTIFICATION/COMMENTS	BALANCE DUE
☐ Yes ☐ No		

4

PRESCRIPTION NUMBER	REFILL CODE	NURSING HOME	DATE WRITTEN	DATE FILLED	QUANTITY PRESCRIBED	QUANTITY FILLED	TOTAL CHARGE
		☐ Yes ☐ No					

EST. DAYS SUPPLY	NATIONAL DRUG CODE	DRUG NAME	PAYABLE BY PATIENT

PRESCRIBER'S ID	PRESCRIPTION (DIRECTIONS FOR USE)	AUTHORIZATION NUMBER	INSURANCE PAID AMOUNT

GENERIC	JUSTIFICATION/COMMENTS	BALANCE DUE
☐ Yes ☐ No		

PROVIDER CERTIFICATION

I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington; the claim is just and due; that no part of the same has been paid and I am authorized to sign for the payee; and that all goods furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or mental handicap, and that the foregoing information is true, accurate and complete.

NET TOTAL BILLED

SIGNATURE OF PHARMACIST (IN INK) DATE

X

DSHS 13-714 (REV. 05/2002) (AC 10/2002)

MAIL TO: DIVISION OF PROGRAM SUPPORT, PO BOX 9245, OLYMPIA WA 98507-9245